SECTION 2

HOSPICE CARE PROVIDER MANUAL

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1 GENERAL POLICY

A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. Hospice care comes from the recognition that the impending death of an individual warrants a change in focus from curative care to palliative care. Hospice care is to be rendered by a Medicare-certified hospice and provided in accordance with Medicare regulations.

Section 9505 of Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), permits states to provide hospice care under their Medicaid State Plans. COBRA requires the State to provide hospice services in the same amount, duration, and scope as Medicare services and at the same payment rate.

Effective March 1, 1989, the Utah Medicaid program added hospice care as a covered Medicaid service. Effective October 1, 1997, all Medicaid hospice services (including room and board in a nursing facility for Medicare hospice clients) must be prior authorized.

1 - 1 Definitions

Hospice means a public agency or private organization that is primarily engaged in providing care to terminally ill individuals, meets the Medicare conditions of participation for hospice, and has a valid provider agreement with the Division of Health Care Financing (DHCF). This provider agreement must be separate and distinct from other provider agreements.

Terminally ill means a medical prognosis that the individual's life expectancy is six months or less if the terminal illness runs its normal course.

Attending physician means a doctor of medicine or osteopathy who is designated by the individual at the time he or she elects to receive hospice care as having primary responsibility for the individual's medical care and treatment.

Bereavement counseling means counseling services provided to the individual's family after the individual's death.

Medical social services mean the provision of counseling and assessment activities which contribute meaningfully to the treatment of an individual's condition.

Interdisciplinary group means a group of qualified individuals with expertise in meeting the special needs of hospice recipients and their families. This group must consist of the following:

- physician;
- registered nurse;
- social worker; and
- pastoral or other counselor.

Election statement means a signed statement by a terminally ill individual or his/her representative indicating the election of hospice care and filed by the individual with a particular hospice which maintains the certification statement.

1 - 2 Eligible Recipients

Hospice care is available to categorically and medically needy individuals under Medicaid.

1 - 3 Access Requirements

Hospice services must meet the requirements relating to certification of terminal illness and the client's election of hospice care, as described in this chapter.

A. Certification of Terminal Illness

1. The hospice must obtain physician certification by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician that an individual is terminally ill. The physician certification statements may be completed up to two weeks before hospice care is elected.

2. If written certification is not obtained within two calendar days following the initiation of hospice care, a verbal certification may be made within two days following the initiation of hospice care, with a written certification not later than eight days after care is initiated. Payment begins with the day of certification.

3. The hospice benefit is available only to individuals who are terminally ill. Therefore, a hospice may discharge an individual who is later declared or found to be no longer terminally ill. Discharge may also be necessary when the patient moves out of the service area.

B. Election of Hospice

1. The individual must elect hospice care by filing an election statement with a particular hospice.

2. An election may also be filed by a representative authorized by state law to elect or revoke hospice care or terminate medical care on behalf of a terminally ill individual.

3. If a client is dually enrolled in Medicare and Medicaid, he or she must receive hospice coverage under Medicare. However, the terminally ill individual must also elect the hospice benefit under Medicaid at the same time. This allows Medicaid to pay for Medicare coinsurance and/or room and board for individuals residing in a nursing facility.

4. Individuals receiving hospice care must waive all rights to Medicaid coverage except for the services of a designated family physician and services unrelated to the terminal illness.

C. A plan of care must be established by the interdisciplinary group. At least one of the persons involved in developing the initial plan must be a nurse or physician. The plan of care must be consistent with the hospice philosophy of care. This plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care.

D. The hospice must send (1) a copy of the election form and plan of care to the Division of Health Care Financing (DHCF) after the client elects hospice care, and (2) notify DHCF when the patient is no longer receiving hospice care.

Mail the election form or notification to:

Utah Department of Health
Division of Health Care Financing
Long Term Care Bureau
PO Box 3101
Salt Lake City, UT 84114-3101

or send by FAX to (801) 536-0157

E. Revocation of Hospice

An individual or representative may revoke the election of hospice care at any time. To revoke the election of hospice care, the individual must give the hospice a signed statement revoking the election of hospice care for the remainder of that election period with the date revocation is to be effective. The individual forfeits the remainder of the election period. If the hospice period is not divided into periods, the revocation is permanent. **Medicaid hospice is not divided into periods.**

2 SERVICE COVERAGE

Services must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions.

Effective October 1, 1997, all Medicaid hospice services (including room and board in a nursing facility for Medicare hospice clients) must be prior authorized. When you request prior authorization, you must have the information listed on page 13. You may obtain a prior authorization number by calling Suzanne Slaughter at (801) 538-6634. You may also fax your request to Suzanne Slaughter at (801) 536-0157.

2 - 1 Core Services

Hospice employees must provide the services listed below. A hospice may use contracted staff to supplement hospice employees during periods of peak patient loads or other extraordinary circumstances. The hospice remains responsible for the quality of services provided by contracted staff.

A. Nursing care provided by or under the supervision of a registered nurse;

B. Medical social services provided by a qualified social worker under the direction of a physician;

C. Administrative and general supervisory activities performed by physicians who are employees of, or working under arrangements made with, the hospice;

D. Counseling services for the individual and family members or other persons caring for the person at home.

2 - 2 Other Covered Services

The following additional services must also be provided directly by, or made available by, the hospice.

A. Short-term inpatient care in a participating hospice inpatient unit, or a hospital, skilled nursing, intermediate care, or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home;

B. Medical appliances and supplies, including drugs and biologicals. Medical supplies include those that are part of the written plan of care. Only drugs which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the client's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care.

C. Home health aide and homemaker services furnished by qualified aides; home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the client, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the client. Aide services must be provided under the general supervision of a registered nurse.

D. Physical therapy, occupational therapy, and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills;

E. Special Modalities: Chemotherapy, radiation therapy, and other modalities may be used for palliative purposes if it is determined that these services are needed for palliation. This determination is based on the individual's condition and the hospice's care giving philosophy. **No additional Medicaid payment may be made regardless of the cost of the services.**

F. Special Coverage Requirements: Continuous home care is to be provided only during a period of crisis. A period of crisis is a period in which a client requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse, and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care must be provided during a 24-hour day which begins and ends at midnight. This care need not be continuous, i.e., four hours could be provided in the morning and another four hours provided in the evening of that day. Homemaker and aide services may also be provided to supplement the nursing care.

Respite care is short-term inpatient care provided to the client only when necessary to relieve the family members or other persons caring for the individual at home.

Bereavement counseling consists of counseling services provided to the individual's family after the individual's death. Bereavement counseling is a required hospice service but it is not reimbursable.

3 REIMBURSEMENT

3 - 1 Hospice Care Rates

Hospice services are reimbursable to the hospice only. Medicaid payments for hospice services are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. However, Medicaid will not apply the aggregate caps used by Medicare. The rates will be based on the Medicare rates for Utah. The four types of fixed daily rates are for routine home care, continuous home care, inpatient respite care, and general inpatient care, as described in this chapter

A. Routine home care

The hospice will be paid the routine home care rate for each day the patient is at home and is not receiving continuous care during a crisis. The hospice will be paid the routine home care rate for each day the patient is at home and is not receiving continuous care during a crisis. The rate is paid (1) without regard to the volume or intensity of routine home care services, and (2) when the patient is receiving hospital care for a condition unrelated to the terminal condition.

B. Continuous home care

Continuous home care is to be provided only during a period of crisis. The hospice will be paid the continuous home care rate when continuous home care is provided.

The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of eight hours must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day.

C. Inpatient respite care

The hospice will be paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. Payment for respite care will include the date of admission but not the date of discharge. Respite care will not be reimbursed for more than five consecutive days at a time.

Respite care may not be provided when the hospice recipient is a nursing home resident.

D. General inpatient care

Payment at the inpatient rate is made when general inpatient care is provided.

During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20

percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. The inpatient day limit on both inpatient respite care days and general inpatient care days does not apply to recipients afflicted with acquired immunodeficiency syndrome (AIDS).

A hospice may not arrange to provide inpatient services in a V.A. or military hospital because Medicaid cannot pay for services which have already been paid by another governmental entity.

3 - 2 Date of Discharge

For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged or deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

3 - 3 Physician Services

Costs for administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. These activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies.

Direct patient care provided by the medical director, hospice-employed physician, or consulting physician should be billed in accordance with the usual Medicaid reimbursement policy for physician services. This reimbursement is in addition to the daily rates.

Reimbursement to an independent attending physician will be made in accordance with the usual Medicaid reimbursement methodology for physician services and is not based on whether the services are for the terminal illness or an unrelated condition.

Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.

The hospice should notify the Division of Health Care Financing of the election and the name of the physician who has been designated as the attending physician whenever the attending physician is not a hospice employee.

3 - 4 Services Not Related to Terminal Illness

Medical services for illnesses or conditions not related to the recipient's terminal illness will not be covered through the hospice program but will continue to be payable when billed by the appropriate provider in the usual manner.

3 - 5 Managed Care Plans (MCPs) and Hospice

If a hospice recipient is enrolled in a MCP, the hospice selected by the recipient must have a contract with the MCP. The MCP will be responsible to reimburse the hospice for hospice services.

4 HOSPICE RECIPIENTS RESIDING IN NURSING FACILITIES (NFs) OR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICFs/MR)

4 - 1 Medicaid Hospice

Medicaid hospice services are funded by Medicaid and provided by a Medicare-certified hospice which also has a provider agreement with the Division of Health Care Financing.

A. Agreement with NF or ICF/MR

When an individual residing in a nursing facility elects hospice care, the hospice and the facility must have a written agreement under which the hospice is responsible for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual. **Room and board includes performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.**

The agreement includes at least the following:

1. identification of the services to be provided;
2. a stipulation that services may be provided only with the express authorization of the hospice;
3. the manner in which the contracted services are coordinated, supervised, and evaluated by the hospice;
4. the delineation of the role(s) of the hospice and the NF or ICF/MR in the admission process, recipient/family assessment, and the interdisciplinary group care conferences;
5. requirements for documenting that services are furnished in accordance with the agreement;
6. the qualifications of the personnel providing the services.

B. Requirements for Admission to NF or ICF/MR

Even though a nursing facility is the hospice recipient's residence for purposes of the hospice benefit, the facility must still comply with the requirements for participation in Medicare and/or Medicaid. This means that the resident must be assessed, have a plan of care, and be provided with the services required under the plan of care. This result can be achieved through cooperation between the hospice and facility staff with the consent of the resident. In this example, the hospice team may participate in completing the RAI (Resident Assessment Instrument).

C. Record keeping in NF or ICF/MR

The hospice must establish and maintain a clinical record for every individual receiving care and services. The record must be complete, promptly and accurately documented, readily accessible, and systematically organized to facilitate retrieval.

Entries are made for all services provided. Entries are made and signed by the person providing the services. The record includes all services whether furnished directly or under arrangements made by the hospice. Each individual's record contains--

1. the initial and subsequent assessments;
2. the plan of care;
3. identification data;
4. consent and authorization and election forms;
5. pertinent medical history; and
6. complete documentation of all services and events (including evaluations, treatments, progress notes, etc.)

The survey team will look for necessary documentation of services provided when they survey a nursing facility.

D. Reimbursement

1. Reimbursement will be made to the hospice. The hospice will receive its routine daily rate plus an allowance for the facility's room and board. **(The room and board allowance is 95 percent of the facility's Medicaid per diem rate for that individual in that facility. Medicaid's MMIS will automatically calculate 95 percent of the daily rate for that nursing facility upon receipt of the billing.)** The facility cannot bill Medicaid separately. The hospice receives Medicaid's payment and must, in turn, reimburse the facility for room and board.

2. MCPs

   a. If a recipient is enrolled in a MCP and has elected hospice care before being admitted to a nursing facility, the MCP is responsible to reimburse the hospice for both the hospice care and the room and board.

   b. If a recipient is a resident of a nursing facility before electing hospice care, the hospice may bill Medicaid fee-for-service for the hospice care and the room and board.

3. Resident Cost-of-Care Contributions

   a. When a hospice client in a nursing facility has a monetary obligation to contribute to his/her cost of care in the facility, the nursing facility will continue to collect and retain the contribution the same as for a non-hospice nursing facility resident.

   b. The hospice will bill Medicaid for the room and board at the daily per diem rate of that nursing facility. Medicaid's MMIS will calculate 95 percent for the room and board, and will pay the hospice the 95 percent amount minus the client's cost-of-care obligation.

   c. The hospice will reimburse the nursing facility the reduced amount received from Medicaid.

4. Billing Instructions

   Hospices will bill the room and board for NFs or ICFs/MR in the same manner as for other hospice services–CMS 1500 or UB-92.

4 - 2 Medicare Hospice

Medicare hospice services are funded by Medicare and provided by a Medicare-certified hospice.

A. If a recipient is dually enrolled in Medicare and Medicaid, he/she must receive hospice coverage under the Medicare benefit. However, the hospice must submit the enrollment form to Medicaid.

B. When a recipient is receiving hospice services under Medicare, Medicaid will provide for payment of any coinsurance amounts, as well as room and board, if the recipient resides in a nursing facility.

C. Medicare hospice services will be billed to Medicare in the usual manner. Room and board will be billed to Medicaid the same as for a Medicaid hospice recipient.

HOSPICE PROCEDURE CODES

NOTE: All Medicaid hospice services (including room and board in a nursing facility for Medicare hospice clients) must be prior authorized. When you request prior authorization, you must have the information listed on page 13. You may obtain a prior authorization number by calling Suzanne Slaughter at (801) 538-6634.

T2042	Routine home care - daily
T2043	Continuous home care - hourly
T2044	Inpatient respite care - daily
T2045	General inpatient care - daily
T2046	Nursing facility room and board - daily

Information Required for Prior Authorization of Hospice Services

NOTE: All Medicaid hospice services (including room and board in a nursing facility for Medicare hospice clients) must be prior authorized. When you request prior authorization, you must have the information listed below. You may obtain a prior authorization number by calling Suzanne Slaughter at (801) 538-6634.

Hospice:	
Date of Admission	
Client Name:	
Age:	
Diagnosis(es):	
Plan of Care:	
Supplies:	
Physician:	
Contact Person:	
Telephone:	
Date *DHCF Notified:	
Medicare Hospice	
Nursing Home:	
Medicaid Hospice	
Managed Care Plan (MCP):	

Medicaid Prior Authorization (PA) Number assigned by *DHCF:

*DHCF. Division of Health Care Financing